| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105475 | A. Building<br>B. Wing | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Terrace of Delray Beach Nursing and Rehabilita | 5430 Linton Blvd<br>Delray Beach, FL 33484 |

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|---|---|
| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on interview and record review, the facility failed to ensure the provision of showers as per facility schedule for 1 of 4 sampled residents, Resident #48.<br><br>The findings included:<br><br>Review of the record revealed Resident #48 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a 0 to 15 scale, indicating he had minimal cognitive impairment.<br><br>Review of the record lacked any evidence of the provision of showers. A progress note dated 04/04/24 at 9:21 AM documented to please have the resident sit in his wheelchair after his shower one time a day every Tuesday, Thursday, and Saturday. This note also documented if the resident refused to get a shower to phone the resident's significant other / power of attorney (POA), and the phone number was provided.<br><br>A care plan initiated 01/11/23 documented Resident #48 did reject care, including showers, but lacked the newer intervention to phone the significant other should he refuse.<br><br>Review of the progress notes subsequent to the 04/04/24 note, lacked any documented refusal of showers or attempts to phone the significant other for assistance, except for a generic statement of refusals during the care plan meeting on 07/18/24.<br><br>During an interview on 07/28/24 at 11:54 AM, when asked if he was receiving care and assistance from the staff, Resident #48 stated no. When asked what the staff were not providing, the resident stated they didn't take care of him, and asked the surveyor to call his girlfriend.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 07/28/24 at 12:17 PM, the resident's girlfriend, who was also his emergency contact and POA voiced concerns that included the lack of showers. The significant other stated she has gone to every meeting (referring to the quarterly care plan meetings) and complained the resident was not getting his showers. The significant other stated staff will then give him one shower the day after the meeting, and then no more for weeks and weeks. When asked if the resident refuses or resists showers, the significant other stated when he was first admitted to the facility he would refuse, but if staff would offer a shower now he would take one. The significant other stated she had told them a hundred times, if he did refuse, to call her, and she would call him and would be able to encourage or convince him to take a shower.<br><br>During an interview on 07/28/24 at approximately 1:15 PM, when asked if he would take a shower if offered, Resident #48 stated, Yes, every time. During a subsequent interview on 07/30/24 at 12:33 PM, when asked if he had had a shower this week, the Resident #48 stated, No.<br><br>During an interview on 07/31/24 at 10:30 AM, when asked about showers for Resident #48, Staff A, Registered Nurse (RN), stated, sometimes the resident is non-compliant, but if we call the significant other, he will comply. When asked about the shower timing, Staff A explained there was a written schedule, and if a resident refused, the Certified Nursing Assistants (CNAs) were to report to the nurse, who would try to encourage the resident to shower. Staff A stated the refusal should be documented by the nurse in the progress notes.<br><br>During an interview on 07/31/24 at 10:54 AM, when asked who was on the shower schedule for her assignment for the day, Staff B, the CNA assigned to Resident #48 and seven other residents, stated that none of her residents get a shower that day (Wednesday), and that she knows her residents and when they get showers. When asked specifically when Resident #48 would get a shower, Staff B went over to a bulletin board behind the nurses' station but was unable to find the shower schedule. Multiple staff in the area then began to look for the written shower schedule but could not find one. When asked further about the showers, Staff B then stated she floated to that unit today and does not know the shower schedule for that day's assignment. Staff C, Licensed Practical Nurse (LPN), who was standing nearby and also searching for the shower schedule stated, So she should look in the book and know who gets showers. Staff C found a shower schedule in a binder for the 7 AM to 3 PM staff but was unable to locate a schedule for the 3 PM to 11 PM shift. Review of the 7 AM to 3 PM shower schedule revealed Staff B had one shower to provide during her shift.<br><br>On 07/31/24 at 12:11 PM, the Assistant Director of Nursing (ADON) provided the surveyor with a copy of the shower schedule for both shifts. The ADON stated she had a copy in her office, but agreed there should be one available at the nurses' station. The ADON was informed of the concern related to the lack of showers for Resident #48. Review of the shower schedule provided by the ADON revealed Resident #48 was scheduled for a shower during the 3 PM to 11 PM shift on Monday, Wednesdays, and Fridays. During a side-by-side review of the CNA documentation, the ADON agreed there was no place to enter the provision of a shower. The ADON stated they had been working on the documentation for the CNAs since the company change in May 2023, but had not gotten to each resident. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>33103<br><br>Based on record review and interview, the facility failed to ensure staff awareness and implementation of DNR (Do Not Resuscitate) status for 1 of 1 sampled resident, Resident #70.<br><br>The findings included:<br><br>Review of the Policy, titled, Communication of Code Status, Implemented 05/01/24, documented, in part, it is the policy of this facility to adhere to residents rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information.<br><br>1. The facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive.<br><br>2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to:<br><br>a. Full Code b. Do Not Resuscitate c. Do Not Intubate d. Do not Hospitalize<br><br>3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record.<br><br>4. The designated sections of the medical record are: Physician Orders, Care plan and Documents.<br><br>5. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code.<br><br>6. The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services.<br><br>7. The Social Services Director shall maintain a list of residents who have an Advance Directive on file.<br><br>8. The resident ' s code status will be reviewed at least quarterly during care plan meeting and documented in the medical record.<br><br>Review of the electronic medical record (EMR) documented the code status as a Full Code.<br><br>Review of the Physician's orders dated 02/28/24 revealed an order for Full Code.<br><br>Further review, under the document tab, revealed a DNR [Do Not Resusitate] document that was dated 03/26/24. The physician signed the DNR document on 05/08/24 and showed effective 06/21/24 in the document tab. A review of the Care Plan documented a full code.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/29/24 at 1:57 PM with Staff C, Licensed Practical Nurse (LPN), she was asked to pull up Resident #70 electronic record and was asked what Resident #70 code status was. She stated she is a full code. The surveyor asked what the physician's order showed. Staff C stated the order is a full code status and was ordered on 02/28/24. When the surveyor asked her to review there area Under the document tab, she stated their is a DNR signed by the physician on 05/08/24 and date of document is 03/26/24 when the document was filled out. When asked, Staff C stated the process for knowing what the code status is, I would look at the order and code status. We have a DNR book. When asked to get the book and show the surveyor Resident #70 DNR status in it, she did not see a DNR document in the book. Staff C didn't understand the concern until surveyor pointed it out. She then stated the order needed to be updated. She stated the process after the DNR is signed, is that the Social Worker or the nurse would put the order in the computer.<br><br>An interview conducted on 07/30/24 at 12:35 PM with the son and POA (Power of Attorney) of Resident #70, revealed he had requested a DNR order and thought it was in March 2024 but they were going back and forth and a lot was going on. When the surveyor stated the physician had signed the form in May 2024, he stated it should have been effective when first signed and shouldn't have been delayed that long. |

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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>32078<br><br>Based on record review and interview, the facility failured to provide the appropriate Beneficiary Notification Form (CMS Form 10055/SNF ABN) to 2 of 3 sampled residents, Resident #22 and #70.<br><br>The findings included:<br><br>On 07/31/24, reviews of the Beneficiary Notices provided by the facility for Resident #22 and Resident #70 revealed they were discharged from Part A Medicare services and the beneficiary notices were completed. The residents were not provided with the required documentation, CMS Form 10055 (SNF ABN), at the time of Medicare Part A discharge, as follows:<br><br>1. Record review revealed Resident #22's start date for Medicare Part A services was 07/04/24. His last covered day of Part A Services was 07/09/24. The facility initiated the discharge from Part A services when the benefit days were not exhausted, and Resident #22 chose to remain in the facility. The CMS Form 10123 (NOMNC) was provided to Resident #22 on 07/04/24, but the CMS Form 10055 (SNF ABN) was not provided. The SNF ABN is required if the resident has skilled benefit days remaining and is being discharged from Part A services but will continue living in the facility.<br><br>2. Record review revealed Resident #70's start date for Medicare Part A services was 03/22/24. His last covered day of Part A Services was 03/27/24. The facility initiated the discharge from Part A services when benefit days were not exhausted, and Resident #22 chose to remain in the facility. The CMS Form 10123 (NOMNC) was provided to Resident #22 on 03/22/24, but CMS Form 10055 (SNF ABN) was not provided. The SNF ABN is required if the resident has skilled benefit days remaining and is being discharged from Part A services but will continue living in the facility.<br><br>On 07/31/24 at 2:10 PM, an interview was conducted with the Social Services Director (SSD), who is responsible for providing residents with the Beneficiary Notices. The SSD stated that she had no knowledge of the CMS Form 10055 (SNF ABN), and she didn't have any copies of the SNF ABN to provide to residents who were discharged from Medicare Part A services and who chose to remain in the facility. A copy of the SNF ABN form was provided to the SSD via email on 07/31/24. The SSD enquired as to how the SNF ABN form was to be completed, so a copy of the instructions for the SNF ABN Form was emailed to her on 07/31/24, along with a copy of beneficiary notice scenarios to show which CMS Forms were needed when residents are discharged from Part A services. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103<br><br>Based on observation and interview, the facility failed to maintain a clean, safe and comfortable environment for the residents as evidenced by the environment not being homelike, carts broken and wheelchairs in disrepair, on the 100 and 200 units.<br><br>The finding included:<br><br>1. During an initial tour on 07/28/24 of the resident's rooms, observations revealed the following:<br><br>a. room [ROOM NUMBER] - The bathroom has paint peeling on the wall underneath the soap dispenser. The grout around the toilet was brown and not white.<br><br>b. room [ROOM NUMBER]A - the sitting chair in the room had a large stain in the middle of the seat as well as a couple of tears on the seat.<br><br>c. the Linen Cart on hallway 100 was observed to be broken.<br><br>2. The following wheelchairs were observed to have torn arm rests:<br><br>room [ROOM NUMBER] bed A<br><br>room [ROOM NUMBER] bed B<br><br>room [ROOM NUMBER]-A<br><br>room [ROOM NUMBER]-B<br><br>room [ROOM NUMBER]-B<br><br>room [ROOM NUMBER]-A.<br><br>Photographic Evidence Obtained.<br><br>3. A secondary tour was completed on 07/31/24 at 11:30 AM with the Maintenance Director and the Regional Maintenance Director. They both acknowledged the findings. The Maintenance Director stated that he relies on the residents and rehab to tell him if the wheelchair arms need to be replaced. He stated he would be going around and auditing all the wheelchairs and would keep a log. He stated he has only been here a couple of months. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137<br><br>Based on policy review, interview, and record review, the facility failed to ensure restorative services were provided for 1 of 1 sampled resident, Resident #54.<br><br>The findings included:<br><br>Review of the policy, titled, Restorative Nursing Programs, implemented on 05/01/24, documented, in part, Policy Explanation and Compliance Guidelines: . 10. A resident's Restorative Nursing Plan will include: . c. Frequency of activities d. Duration of activities . 12. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Aide Documentation Form.<br><br>Record review revealed Resident #54 was admitted to the facility 05/23/23. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #54 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS also documented the resident received 1 day of restorative therapy services during the 7 day look back period.<br><br>Review of the Rehab to Restorative Program Recommendations dated 06/06/23 included the services of Bed Mobility and Active Range of Motion (AROM) with the frequency of services to be determined (TBD).<br><br>Review of the current physician order dated 06/13/23 specified the RNP (Restorative Nurse Program) was to provide AROM and bed mobility services. This order lacked any frequency and or duration.<br><br>Review of Restorative Aide documentation in the electronic medical record (EMR) revealed services for AROM were provided for Resident #54 only twice in the month of July 2024.<br><br>An interview was conducted on 07/31/24 at 1:08 PM with Staff E, Restorative Certified Nursing Assistant (CNA), who when asked how often restorative services were being provided and where it was documented, Staff E stated sometimes the resident refused. Staff F, Restorative CNA stated the program was 3 times a week as a standard of the restorative program. Neither of the Restorative Aides were able to locate documentation for the provision of services 3 days weekly or of the resident's refusal of services.<br><br>During an interview on 07/31/24 at 3:16 PM, when asked what the frequency and duration of activities of residents on restorative therapy were and where it was documented, the Administrator stated the frequency and duration should be documented in the order. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on policy review, observation, interview, and record review, the facility failed to ensure timely and ongoing nail care for 1 of 2 sampled residents reviewed for Activities of Daily Living (ADLs), Resident #22.<br><br>The findings included:<br><br>Review of the policy, titled, Nail Care, implemented 05/01/24, documented, in part, Policy Explanation and Compliance Guidelines: . 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises. 5. The resident's plan of care will identify: a. The frequency of nail care to be provided. b. The type of nail care to be provided. C. The persons responsible for providing nail care (e.g., licensed nurse, nurse aide, podiatrist, activity professional). 7. Procedure: . i. Document completion of task, any complications, or if resident refuses.<br><br>Review of the record revealed Resident #22 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #22 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS documented the resident needed substantial to maximum assistance from staff for all Activities of daily Living (ADLs).<br><br>Review of the care plan initiated 12/08/22 documented Resident #22 had an ADL self-care performance deficit, but lacked any information related to nail care.<br><br>Review of the Certified Nursing Assistant (CNA) tasks section of the electronic medical record revealed a checkmark daily for the nail care task, indicating it was performed each day.<br><br>During an interview and observation on 07/28/24 at 10:00 AM, Resident #22's fingernails were long and dirty, with a dark substance under each nail. When asked about his fingernails, Resident #22 stated, They need to be cut. When asked about the cleaning of his fingernails, the resident explained when the nails are cut, they are cleaned.<br><br>An observation on 07/30/24 at 8:29 AM revealed the fingernails for Resident #22 remained long and dirty. When asked about his fingernails, the resident again stated they need to be trimmed and cleaned, and asked the surveyor if she could do it.<br><br>On 07/30/24 at 11:30 AM, Resident #22 was in bed with different clothing noted. When asked if the CNA provided a bed bath, the resident stated she did. When asked if she cleaned or trimmed his nails, the resident stated no and that he had asked for them to be trimmed last week and they never got done. The resident's fingernails remained long and dirty.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Upon entering the room on 07/31/24 at 11:43 AM, Resident #22 stated, Thank you, as he held up his fingernails to show the surveyor. Resident #22 explained a girl had just came into the room about an hour earlier and trimmed his nails. Staff A, Registered Nurse (RN), who was nearby, stated his nails were trimmed by the Activity Assistant. Staff A was informed the resident's fingernails were long and needed to be cleaned since an observation on 07/28/24, and that the resident stated he had requested his nails be trimmed the previous week. Staff A was also informed the CNAs were documenting the completion of nail care daily.<br><br>During an interview on 07/31/24 at 1:12 PM, when asked how she was involved in resident nail care, the Activity Assistant stated she has a beauty hour weekly where residents come into the Activity room to get their nails done. The Activity Assistant explained she also goes into the rooms of those residents who prefer to stay in their rooms to help with nail care. When asked about Resident #22, the Activity Assistant stated he was on her list for the previous week, but she did not get to him. The Activity Assistant confirmed she had trimmed and cleaned his nails earlier today. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026<br><br>Based on observation, interviews, record and policy review, the facility failed to provide timely care and treatment for a skin tear for 1 of 1 sampled resident reviewed for skin conditions, Resident #1.<br><br>The findings included:<br><br>The facility's policy, titled, Skin Integrity-Skin Tear, implemented on 05/01/24, documented, in part, the following: When a skin tear is discovered, the nurse shall complete an incident report. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any skin tears, or any changes in the resident's medical condition. Interventions will be modified in a resident's plan of care as needed.<br><br>Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Urinary Tract Infection, Heart Failure, and Unspecified Peripheral Vascular Disease. Resident #1 was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15 on her admission minimum data set.<br><br>On 07/28/24 at 9:27 AM, an observation was made of a white bandage on the resident's right forearm with no date on the bandage. Photographic evidence obtained. At this time, the resident was asked if she knew why she had the bandage on and she stated she thought she scraped her arm on the bed rail.<br><br>On 07/29/24 at 10:12 AM, another observation of Resident #1's right forearm revealed no bandage on the arm but an observation of a skin tear on the arm.<br><br>On 07/29/24 at 3:55 PM, an interview was conducted with Staff H, Registered Nurse (RN), who stated she had been taking care of Resident #1 yesterday and today and does not know anything about the Band-Aid on the resident's arm.<br><br>An interview with the Infection Control Preventionist on 07/29/24 at 4:05 PM revealed she put the dressing on the arm yesterday because she saw a hematoma on the right arm. She stated, today she saw the skin tear and put a Band-Aid on it. Photographic Evidence Obtained. The surveyor asked if she called the physician for an order for the skin tear dressing and she stated she did not. She then took the Band-Aid off that was on the skin tear.<br><br>Review of the Electronic Health Record (EHR) revealed no note about the skin tear, no incident report and no care plan for the skin tear.<br><br>32078 |

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| | 105475 | A. Building<br>B. Wing | 07/31/2024 |

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| The Terrace of Delray Beach Nursing and Rehabilita | 5430 Linton Blvd<br>Delray Beach, FL 33484 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on policy review, observation, interview, and record review, the facility failed to ensure appropriate indwelling urinary catheter care and maintenance for 2 of 2 sampled residents, as evidenced by staff failed to provide appropriate urinary catheter care for Resident #22 and failed to ensure an anchoring device for the urinary catheter of Resident #77. Both residents had a history of urinary tract infections (UTIs).<br><br>The findings included:<br><br>Review of the policy, titled, Catheter Care, implemented 05/01/24 documented, in part, Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . This policy further instructed care for the male was for staff to first cleanse the penis in the area closest to meatus (insertion site), followed by the shaft of the penis moving down or away from the insertion site, and lastly cleaning the urinary tube cleansing outward away from the body, holding the tubing to ensure the catheter remains in place and is not pulled.<br><br>Review of the policy, titled, Catheterization of a Male, implemented 05/01/24, documented, in part, Policy: Urinary catheterizations will be performed in accordance with current standards of practice to minimize risk for bacterial contamination . 9. s. ii. Secure the catheter to the resident's upper thigh or lower abdomen .<br><br>1. Review of the record revealed Resident #22 was admitted to the facility on [DATE], was transferred to the hospital related to complications with his indwelling urinary catheter on 06/17/24 and readmitted to the facility on [DATE]. Resident #22 returned to the facility with the urinary catheter.<br><br>Further review of the record revealed Resident #22 had Urinary Tract Infections (UTIs) on 02/09/24 and 02/25/24, both times with the cultures indicating E. Coli (Escherichia Coli), a bacteria found in the stool, but not in urine, which was indicative of poor personal or catheter care. These UTIs also indicated the bacteria as MDROs (multidrug-resistant organisms), which are bacteria that have become resistant to certain antibiotics. Resident #22 was also diagnosed during the hospitalization of 06/17/24 with another UTI with MDROs.<br><br>An observation of care for the indwelling urinary catheter for Resident #22 was made on 07/30/24 at 9:41 AM with Staff D, Certified Nursing Assistant (CNA). The CNA cleaned the catheter tubing first, with a back and forth (outward and inward) motion using one cloth. Then the CNA cleaned the resident's inner thighs, followed by the shaft of the penis, and then the end of the penis at the insertion site.<br><br>During an interview on 07/31/24 at 11:55 AM, when asked in what direction she was supposed to cleanse the urinary catheter tubing, Staff D appropriately explained from close to the body outward. When asked why she went back and forth on the catheter tubing, the CNA stated, I did? I'm sorry.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Assistant Director of Nursing (ADON) was asked to provide the above-mentioned policies on 07/31/24 during the afternoon and was informed there were concerns with the urinary catheter care and maintenance.<br><br>2. Review of the record revealed Resident #77 was admitted to the facility on [DATE], was transferred to the hospital related to urinary catheter issues and an elevated white blood count on 02/24/24, with readmission to the facility on [DATE]. The resident returned to the facility with an indwelling urinary catheter.<br><br>Further review of the record revealed orders as of 10/05/23 for the use of the indwelling urinary catheter along with the order to secure the tubing using an anchoring device to prevent movement and urethral traction.<br><br>Review of a urinalysis with the culture and sensitivity dated 01/12/24 documented the resident had a UTI with the organism E. Coli.<br><br>During an interview and observation on 07/28/24 at 9:40 AM, Resident #77 confirmed he had an indwelling urinary catheter, and the drainage bag was noted hooked to the bed frame. When asked if he had a leg strap or anchor on his thigh, Resident #77 pulled down the covers and an adult brief was noted, with no anchor or thigh strap observed. A second observation on 07/30/24 at 4:09 PM also lacked any type of anchor or thigh strap to secure the catheter tubing for Resident #77.<br><br>The ADON was made aware of the concern on 07/31/24 during the afternoon but was unable to confirm as the resident had been transferred to the hospital earlier that day, related to urinary catheter issues. The lack of the anchoring device was observed by two surveyors on both occasions. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026<br><br>Based on observation, interviews, record and policy review; the facility failed to provide pain management for 1 of 1 resident reviewed for pain management (Resident #294); and and failed to provide medications as per physician order for 2 of 5 sampled residents reviewed for unnecessary medications, Resident #4 and #28.<br><br>The findings included:<br><br>The policy of the facility, titled, Pain Management implemented 05/01/24, revealed an assessment or evaluation of pain may necessitate gathering the following information, as applicable to the resident The resident's goals for pain management and his/her satisfaction with the current level of pain control.<br><br>1. Record review documented Resident #294 was admitted to the facility on [DATE] with diagnoses that included Syncope and Collapse, Other symptoms, and signs involving the musculoskeletal system and Presence of cardiac pacemaker. Her Brief Interview for Mental Status (BIMS) score was 14 on the admission minimum data set with an assessment reference date of 07/27/24, indicating the resident was cognitively intact.<br><br>On 07/28/24 at 1:43 PM, an initial interview with the resident was conducted. She stated she had pain on her right chest wall since she fell and they only will give her Tylenol but that does not help. She stated she told the nurses that she needed something stronger but she was always getting Tylenol when she asked for pain medication.<br><br>On 07/29/24 at 10:14 AM, the resident stated she did not get Tylenol all night last night and stated she had pain.<br><br>An interview was conducted with Staff H, Registered Nurse (RN), on 07/29/24 at 3:45 PM. Staff H stated that the resident has not told her that she had pain. She told her that she had a headache or generalized discomfort. She stated if she knew she had pain and was not relieved by Tylenol she would have had her seen by pain management. At that time, the primary physician was in the building and the nurse asked him if he could see the resident today.<br><br>An interview was conducted with Staff I, Licensed Practical Nurse Supervisor, on 07/30/24 at 12:15 PM. She stated she had a conversation with the physician yesterday who told her that he ordered pain medication for the resident and will send the prescription to the pharmacy. Staff I stated that she forgot to put the conversation with the physician in the progress note, and forgot to put the verbal order into the Electronic Health Record (EHR). The medication card for the Tramadol was put in to the medication cart when it was delivered at 6:30 AM today but the order was not in the EHR yet.<br><br>An interview was conducted with Resident #294 on 07/30/24 at 12:45 PM. She stated she did not have pain today. The physician came to see her yesterday and she told him that she had pain and he said he was giving her more medication.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the physician note dated 07/29/24 revealed the resident had right chest wall pain 6 out of 10 since her fall. She is complaining of right chest wall pain not relieved by licocaine patch or Tylenol. I have added some Aleve and also tramadol for now (we are going to get pain management involved).<br><br>32078<br><br>2. Record review documented Resident #4 was admitted to the facility on [DATE] with diagnoses that included Pain. The 5-day Minimum Data Set (MDS) Assessment completed on 07/18/24 documented Resident #4 received an as needed medications for pain, and her Care Plan, initiated on 06/25/24, documented Resident #4 is at risk for Pain.<br><br>Review of physician orders for Resident #4 showed this resident is to receive a Lidocaine Patch, applied to bilateral shoulders topically one time a day for pain. Apply to intact skin and remove patch after a maximum of 12 hours of application (12 hours on and 12 hours off) and remove per schedule.<br><br>Review of the electronic Medication Administration Record (eMAR) showed that nursing staff had documented that Resident #4's Lidocaine patch was NA (not available) from 07/24/24 AM to 07/28/24 AM, the Patch was documented as provided on 07/29/24 AM, but NA (not available) on 07/30/24. there was no monitoring of pain completed on the days the patch was not available or provided.<br><br>No further documentation was found on the eMAR or in the Progress notes regarding a reason for the Lidocaine Patch being unavailable, or what steps were taken to get the medication for the resident.<br><br>3. Record review documented Resident #28 was admitted to the facility on [DATE] with diagnoses that included Chronic Pain Syndrome. The MDS for Significant Change completed on 06/02/24 documented Resident #28 received a scheduled pain medication regimen, and the Care Plan initiated on 06/06/24 documented the resident is at risk for pain.<br><br>Review of physician orders for Resident #28 showed this resident is to receive a Lidoderm Patch 5%, and it is to be applied to affected site topically one time a day for pain. Apply to intact skin and remove patch after a maximum of 12 hours of application (12 hours on and 12 hours off) and remove per schedule (05/15/24 - 07/29/24).<br><br>There was also a physician order for Lotrisone Cream 1-0.05% to be applied to chest, arms, back topically every shift for rash until 07/10/24.<br><br>Review of the eMAR showed that nursing staff had documented that Resident #28's Lotrisone Cream was not available on 07/02/24 for the day and evening shift application times.<br><br>Also, for the Lidoderm (Lidocaine) Patch 5%, there was no documentation on 07/04/24, and nursing staff documented the Lidoderm Patch 5% as NA (not available) on 07/09/24, 07/10/24, 07/12/24, 07/27/24 and 07/28/24. There was no monitoring of pain documented as done on the days the patch was not available / provided, except for 07/09/24 for which the pain level recorded was 0 (zero).<br><br>No further documentation was found on the eMAR or in the Progress notes regarding a reason for the Lotrisone Cream or Lidoderm Patch 5% being unavailable, or what steps were taken to get the medication for the resident.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Director of Nursing was interviewed on 07/31/24 at approximately 12:30 PM. She was unable to provide any further information or documentation as to why the Lidoderm/Lidocaine patches and the Lotrisone cream were marked unavailable, and as to why pain monitoring was not documented<br><br>On 07/31/24 at 1:30 PM, the Pharmacist Consultant was asked to enquire of the Pharmacy if the unavailable medications were provided to the facility. The Pharmacist Consultant stated that the information received from the Pharmacy indicated the medications marked not available were delivered to the facility and should have been available.<br><br>No further information was provided by the facility. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32078<br><br>Based on observation, interview and record review, the facility failed to document pain levels for 2 of 6 sampled residents reviewed for medications (Resident #4 and Resident #28); failed to document Blood Glucose levels before each meal, as ordered 1 of 5 sampled residents reviewed for unnecessary medications (Resident #81); failed to document the percentage of meals eaten for 1 of 4 sampled residents reviewed for nutrition (Resident #70); failed to clarify the type of dialysis received for 1 of 1 sampled resident reviewed for Dialysis (Resident #292); and failed to accurately document the provision of nail care for 1 of 2 sampled residents reviewed for Activities of Daily Living [ADLs] (Resident #22).<br><br>The findings included:<br><br>1a) Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses that included Pain. The 5 day Minimum Data Set (MDS) Assessment completed on 07/18/24 documented Resident #4 received as needed medications for pain, and her Care Plan initiated on 06/25/24 documented Resident #4 is at risk for Pain.<br><br>The physician orders for Resident #4 contained an order for pain monitoring which documented: Monitor and record pain level every shift for pain management.<br><br>Pain Scale:<br><br>Mild pain 1-3<br><br>Moderate pain 4-6<br><br>Severe 7-10.<br><br>Review of the electronic Medication Administration Record (eMAR) and Progress Notes revealed no documentation showing the monitoring of pain levels were completed within Resident #4's record.<br><br>1b. Record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses that included Chronic Pain Syndrome. The MDS for Significant Change completed on 06/02/24 documented Resident #28 received a scheduled pain medication regimen, and the Care Plan initiated on 06/06/24 documented the resident is at risk for pain.<br><br>The physician orders for Resident #28 contained an order for pain monitoring which documented: Monitor and record pain level every shift for pain management.<br><br>Pain Scale:<br><br>Mild pain 1-3<br><br>Moderate pain 4-6<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Severe 7-10.<br><br>Review of the eMAR and Progress Notes revealed no documentation showing the monitoring of pain levels were completed within Resident #28's record.<br><br>On 07/31/24 at approximately 12:30 PM, the Director of Nursing (DON) was asked to assist in locating any documentation showing staff were recording Resident #4's pain levels during each shift. The DON acknowledged that no documentation of pain levels for each shift could be found.<br><br>2. Record review revealed Resident #81 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus Type 2. The MDS assessment completed on 05/03/24 documented the resident diagnosis of Diabetes Mellitus 2 and the receiving of hypoglycemic medication. Resident #81's Care Plan initiated on 04/30/24 documented this resident is at risk for adverse effects of hyper/hypoglycemia and alteration in nutrition / hydration related to diagnosis of Diabetes Mellitus 2.<br><br>Resident #81's physician's orders contained an order for Blood Glucose monitoring before meals. Call MD if Blood Sugar is above 250 or below 60. Review of the eMAR showed that nursing staff are initialing that the monitoring is being done, but the actual blood glucose numbers are not being recorded on the eMAR, within the Vitals section of the electronic record, or anywhere within the Progress Notes. The only documented blood glucose reading of 177 g/dl was recorded on 07/22/24.<br><br>On 07/31/24 at approximately 12:30 PM, the Director of Nursing (DON) was asked to assist in locating any documentation showing that nursing staff were recording Resident #81's blood glucose levels before each meal. The DON acknowledged that no documentation of blood glucose levels, except for the one recording on 07/22/24, could be found for Resident #81.<br><br>33103<br><br>3. Review of Resident #70 electronic medical record (EMR) revealed a physician's order that included an order of 06/13/24 for three snacks daily; Report % [percent] consumed. Review of the Medication Administration Record (MAR) revealed the order began on 06/13/24. There were nurse's initials and a check mark documented this was completed but does not document the % of the snack consumed. Review on the July 2024 Task sheet from 07/02/24-07/31/24 (could only pull 30 days) named monitor eating did not document which meal or snacks were provided but only documented the time and % consumed.<br><br>During an interview on 07/31/24 at 1:23 PM with the Dietician, she stated she has only been in this facility for two months, but has been monitoring her weight loss and added snacks in the last intervention. She pulled up % consumed for each which was 50-75%. She acknowledged that there should be documentation for all three meals plus 3 snacks per day documented. She acknowledged that she did not see snack documentation being completed as this was not being done.<br><br>25404<br><br>4. Review of the policy, titled, Nail Care, implemented 05/01/24, documented, in part,<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Policy Explanation and Compliance Guidelines: . 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 5. The resident's plan of care will identify: a. The frequency of nail care to be provided. b. The type of nail care to be provided. C. The persons responsible for providing nail care (e.g., licensed nurse, nurse aide, podiatrist, activity professional). 7. Procedure: . i. Document completion of task, any complications, or if resident refuses.<br><br>Review of the record revealed Resident #22 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #22 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS documented the resident needed substantial to maximum assistance from staff for all Activities of Daily Living (ADLs).<br><br>During an interview and observation on 07/28/24 at 10:00 AM, Resident #22's fingernails were long and dirty, with a dark substance under each nail. When asked about his fingernails, Resident #22 stated, They need to be cut. When asked about the cleaning of his fingernails, the resident explained when the nails are cut, they are cleaned.<br><br>An observation on 07/30/24 at 8:29 AM revealed the fingernails for Resident #22 remained long and dirty. When asked about his fingernails, the resident again stated they need to be trimmed and cleaned, and asked the surveyor if she could do it.<br><br>On 07/30/24 at 11:30 AM, Resident #22 was in bed with different clothing noted. When asked if the CNA provided a bed bath, the resident stated she did. When asked if she cleaned or trimmed his nails, the resident stated no and that he had asked for them to be trimmed last week and they never got done. The resident's fingernails remained long and dirty.<br><br>Resident #22's fingernails were trimmed and cleaned on 07/31/24 at about 10:45 AM.<br><br>Review of the care plan initiated 12/08/22 documented Resident #22 had an ADL self-care performance deficit, but lacked any information related to nail care.<br><br>Review of the Certified Nursing Assistant (CNA) tasks section of the electronic medical record revealed a checkmark daily for the nail care task, indicating it was performed each day.<br><br>39026<br><br>5. Record review revealed Resident #292 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (ESRD), Depression and Anemia.<br><br>Review of the care plan for Resident #292 revealed a care plan for hemodialysis and peritoneal dialysis. An interview was conducted with Staff G, Minimum Data Set (MDS) Coordinator, on 07/31/24 at 9:30 AM. She stated she should not have a care plan for peritoneal dialysis, only hemodialysis and cancelled the care plan for peritoneal dialysis. |

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| F 0847<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>32078<br><br>Based on record review and interview, the facility failed to state in their Admission Agreement (page15, Item #26) that Arbitration is not a requirement for admission or a requirement to continue to receive care at the facility. This affects all current residents who have signed the admission agreement, 88 of 88 residents at the time of survey.<br><br>The findings included:<br><br>Review of the facility's 'Arbitration Agreement Program Guide' and 'Arbitration Agreement' was completed on 07/30/24. The separate 'Arbitration Agreement' and 'Arbitration Program Guide' contained all required regulatory language. However, within the Admission Agreement (Agreement between the Facility and Resident / Representative), there is a paragraph on page 15 (Item #26) which stated:<br><br>WAIVER OF RIGHT TO JURY TRIAL. BY SIGNING THIS AGREEMENT RESIDENT AND RESPONSIBLE PARTY ARE WAIVING (A) THE RIGHT TO A JURY TRIAL FOR ANY CLAIM(S) BROUGHT HEREIN AND (B) INSOFAR AS THE ARBITRATION AGREEMENT IS EFFECTIVE ARE AGREEING TO ARBITRATE CLAIMS PROVIDED FOR THEREIN INCLUDING ANY AND ALL CLAIMS ARISING OUT OF OR RELATED TO THE FACILITY SERVICES PROVIDED HEREUNDER TO RESIDENT, INCLUDING, SPECIFICALLY, RESIDENT'S MEDICAL CARE AND TREATMENT.<br><br>Even if the resident / representative chose not to sign the separate 'Arbitration Program Guide' and 'Arbitration Agreement,' the above paragraph contained within the Admission Agreement (Resident Contract), each resident / representative seeking admission to the facility was being required to sign an arbitration agreement as a condition of admission and/or as a requirement to receive care and services at the facility. Nowhere in this paragraph did it inform the resident / representative that they are not required to agree to this Arbitration Agreement as a condition for admission or to receive care and services, nor does it give the resident / representative the right to rescind the agreement within 30 days of signing it.<br><br>On 07/31/24 at 9:56 AM, an interview was conducted with the Admissions Director. She was shown the paragraph #26 on page 15 and informed that this paragraph in the admission agreement was requiring every person that signs the Admission Agreement to waive their right to a jury trial. The wording of paragraph #26 is not in line with Federal regulation regarding Arbitration Agreements. She stated she would inform the new owners that the Admission Agreement must be amended to remove this paragraph in the Agreement.<br><br>On 07/31/24 at approximately 12:45 PM, the owner of the facility was informed by this surveyor of the concern with the wording contained in paragraph #26 on page 15 of the admission agreement, and the lack of information in the paragraph that informs the resident that they are not required to agree to waive their right to a jury trial. The owner acknowledged understanding of the concern with the wording of paragraph #26. |

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|---|---|---|---|
| | 105475 | A. Building<br>B. Wing | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Terrace of Delray Beach Nursing and Rehabilita | 5430 Linton Blvd<br>Delray Beach, FL 33484 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026<br><br>Based on observation, interview, record and policy review, the facility failed to have an effective infection control program related to care and services provided to residents on Enhanced Barrier Precautions which affected 5 of 20 sampled residents on Enhanced Barrier Precautions (EBP), Residents #292, #194, #1, #22, and #77.<br><br>The findings included:<br><br>The facility's policy, titled, Enhanced Barrier Precautions, implemented on 05/01/24 and revised on 05/28/24, revealed, in part:<br><br>2b. An order for enhanced barrier precautions will be obtained for residents with any of the following:<br><br>i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO.<br><br>3. Implementation of Enhanced Barrier Precautions:<br><br>b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.<br><br>4. High-contact resident care activities include:<br><br>a. Dressing<br><br>b. Bathing<br><br>c. Transferring<br><br>d. Providing hygiene<br><br>e. Changing linens<br><br>f. Changing briefs or assisting with toileting<br><br>g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters.<br><br>1. Record review documented Resident #1 was admitted to the facility on [DATE] with diagnoses that included Urinary Tract Infection (UTI), Heart Failure, and Unspecified Peripheral Vascular Disease. Review of the Admission Minimum Data Set MDS) asssessment documented Resident #1 was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the physician orders for Resident #1 revealed an order for Enhanced Barrier Precautions for sacral wound dated 06/19/24. Observation of her resident's room on 07/28/24 at 10:38 AM and 07/29/24 at 11:07 AM revealed no sign for Enhanced Barrier Precautions and no Personal Protective Equipment (PPE) cart available at or near the door.<br><br>2. Record review documented Resident #194 was admitted to the facility on [DATE] with diagnoses that included Pneumonia, Nontraumatic Intracranial Hemorrhage, and Dysphagia.<br><br>On 07/29/24 at 9:13 AM, an observation of medication administration via Percutaneous Endoscopic Gastrostomy (PEG) tube was made. An Enhanced Barrier Precaution sign was in the resident's room on top of a Personal Protective Equipment (PPE) cart. Staff J, Registered Nurse (RN), was observed administering medication into the PEG tube with no gown on.<br><br>An interview was conducted Staff J on 07/29/24 at 2:30 PM. He stated that he was in-serviced that they put a gown on and gloves for catheter care, IV (intravenous) care, and wound care. When asked if he had to wear a gown to administer medication via PEG tube, he stated he was not sure about that.<br><br>3. Record review documented Resident #292 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease, Depression and Anemia. Resident #292 attends in-house hemodialysis on Tuesday, Thursday and Saturday. Observation of the resident's room on 07/28/24 at 10:38 AM and 07/29/24 at 11:07 AM revealed no sign for Enhanced Barrier Precautions and no Personal Protective Equipment (PPE) cart available in the room or at or near the door.<br><br>A physician order was placed in her Electronic Health Record (EHR) on 07/29/24 for Enhanced Barrier Precaution due to 'dialysis catheter'. There was no care plan for Enhanced Barrier Precautions placed in the EHR.<br><br>An interview with the Infection Control Preventionist was conducted on 07/29/24 at 3:13 PM. She initially stated the rooms with residents with dialysis do not need the Enhanced Barrier Sign with available PPE. The Enhanced Barrier Precautions policy was reviewed with the Infection Control Preventionist who then stated the nurse should have worn a gown during medication administration via PEG tube and she also stated that residents with dialysis should be on EBP. She stated she gave in-services on EBP on 05/24/24.<br><br>25404<br><br>4. Review of the record revealed Resident #22 was admitted to the facility on [DATE]. Review of the record revealed Resident #22 had a Urinary Tract Infection (UTI) as per the laboratory results reported on 02/09/24. This urinalysis and culture reported the organism was ESBL (extended-spectrum beta-lactamase), classified as an organism resistant to antibiotic, necessitating the use of contact precautions with PPE (personal protective equipment). This infection was treated with an antibiotic for seven days. Further review of the orders and corresponding Medication Administration Record (MAR) revealed contact precautions for just three days as of the evening shift on 02/09/24.<br><br>During a side-by-side record review and interview on 07/31/24 at 9:54 AM, the Infection Control Preventionist confirmed she would expect the contact precautions for a resident with an active MDRO to be maintained through the entire dose of antibiotics.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the current orders revealed Resident #22 had an indwelling urinary catheter, with care to be provided every shift, and maintaining and implementing enhanced barrier precautions.<br><br>During an observation on 07/28/24 at 9:57 AM, Resident #22 was in bed and was noted to have a urinary catheter. A small rolling plastic three drawer container was noted near the roommate's dresser with PPE, but no sign indicating EBP use was observed.<br><br>A second observation on 07/29/24 at 11:50 AM revealed the same small container with still no EBP sign.<br><br>An observation of direct personal care for Resident #22 was made on 07/30/24 at 9:41 AM with Staff D, Certified Nursing Assistant (CNA). The small rolling plastic drawer had been removed and a larger three drawer plastic container was noted between the two beds, as both residents had indwelling urinary catheters, and an EBP sign was noted on top of the PPE storage bin. Staff D provided personal care to Resident #22, but at no time donned a gown.<br><br>During an interview on 07/31/24 at 11:55 AM, when asked about the use of a gown during direct care of a resident with an indwelling urinary catheter, Staff D stated she was not aware she needed to wear a gown, or she would have done so.<br><br>5. Review of the record revealed Resident #77 was admitted to the facility on [DATE] and was admitted with an indwelling urinary catheter. Review of the orders revealed Enhanced Barrier Precautions (EBPs) were initiated as of 05/20/24.<br><br>An observation on 07/28/24 at 9:40 AM revealed Resident #77 in bed and an urinary drainage device noted hooked to the bed frame. A small storage bin was noted near the resident's dresser that contained PPE. No sign for EBP was noted on the door or in the room. A subsequent observation on 07/29/24 at 11:46 AM still revealed a lack of an EBP sign.<br><br>51137<br><br>6. Review of the record revealed Resident #40 was admitted to the facility on [DATE] with the need to be fed via PEG tube (percutaneous endoscopic gastrostomy, a surgically placed feeding tube directly into the stomach), secondary to Parkinson's Disease and the inability to swallow. An order dated 11/15/24 included the resident was to be fed continuously via the PEG tube. An additional order dated 05/20/24 documented to maintain Enhanced Barrier Precautions (EBP) every shift due to the indwelling device.<br><br>Observations on 07/28/24 at 11:15 AM and 07/29/24 at 11:50 AM revealed Resident #40 in bed with the feeding pump at bedside and tube feeding noted. There was a small three drawer container with PPE (personal protective equipment) inside the room. There was no sign indicating the resident was on Enhanced Barrier Precautions, to instruct staff on when and how to use the PPE. Photographic Evidence Obtained.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/29/24 at 3:40 PM, the spouse confirmed Resident #40 was fed only via the PEG tube. When asked if staff were using the gowns during direct care for the resident, the wife stated, No. The spouse explained she visits daily and often arrived at the facility when staff were providing care to her husband, and staff had not been wearing the gowns. The spouse further volunteered the small three drawer container just showed up one day with no explanation. When explained the use EBP, the wife stated she had not been told about the precautions. |

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| F 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide bedrooms that don't allow residents to see each other when privacy is needed.<br><br>33103<br><br>Based on observation and interview, the facility failed to provide privacy curtains for residents in 14 resident rooms (Rooms 121-133) for Bed A, which is closest to the door, and affecting 2 of 2 sampled Residents #40 and #77.<br><br>The findings included:<br><br>During an initial tour on 07/28/24 at 9:39 AM, the surveyor observed that Residents #77, residing nearest the door (Bed A), did have no privacy curtains.<br><br>On 07/29/24 at 11:28 AM, the surveyor observed that Resident #40, residing by the door, did not have privacy curtains.<br><br>On 07/30/24 at 12:07 PM, the surveyor observed Staff K, RN (Registered Nurse), providing tube feeding to Resident #40. The nurse stated, I'd pull the privacy curtain, but there is no privacy curtain.<br><br>During an interview on 07/30/24 at 2:45 PM, the spouse of Resident #40 stated the privacy curtain has been missing for many months. The spouse explained, 'the curtain was there for about two years and then all of a sudden one day it was gone.'<br><br>Another tour was completed on 07/31/24 at 11:00 AM with the Maintenance Director and Regional Maintenance Director. It was observed that none of the rooms on one hallway, for rooms 121 to 133, have privacy curtains by bed A (nearest the door). It was observed that the middle curtain, between the two beds, had widths which were short and did not give complete privacy between Bed A and Bed B (nearest window). The Maintenance Director did not know why the curtains were missing. They both acknowledged that there should be curtains at the beds nearest the doors (Bed As), and longer curtains, width-wise, between the two beds in each room. |